Ethical physician incentives - from carrots and sticks to shared purpose

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Ethical Physician Incentives — From Carrots and Sticks to Shared Purpose

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As health care reform's focus turns to change in U.S. health care delivery, concerns about the use of incentives for physicians are intensifying. One fear is that incentives will undermine physicians' professional ethos, leading them astray from the primacy of their duty to patients. Another fear is that incentives will be ineffective and merely cause confusion and irritation among patients and clinicians alike, without actually improving outcomes or efficiency.[1] These fears characterize the perspectives of the ethicist and the manager, respectively; we believe that a synthesis of these perspectives is not just possible, but strategically valuable for implementing health care reform.

It seems clear to us that incentives are omnipresent and unavoidable in health care delivery. In any context, decisions are influenced by whatever decision makers stand to gain or lose — not just in economic terms but also in psychological and social terms. Accordingly, the debate over incentives should focus not only on the effect of individual elements (e.g., pay-for-performance bonuses) but also on the full array of financial and nonfinancial incentives used by a health care delivery system. The challenge for the leaders of health care organizations is to shape and align this web of incentives in ways that promote the institution's goals while avoiding unintended harmful consequences, such as over- or underprovision of services.[2,3]

The importance of this process is increasing as financial risk begins to be shifted to provider organizations along with responsibility for patient outcomes, as is currently occurring in accountable care organizations (ACOs). For ACOs to be successful, they must improve the efficiency of care. But they must also maintain or increase their market share, which means that they need to fulfill patients' expectations regarding experience and outcomes. At the same time, to attract and retain excellent clinicians, ACOs must be places where top-quality professionals want to work. Incentives, like targets and performance measures for quality and efficiency, are management tools for steering toward these goals.

How can incentives be developed that are both effective and ethical? Given the complex realities of health care and human behavior, we believe that a simple carrot-and-stick model won't do. The economist and sociologist Max Weber offered a typology of motives for social action that might be useful in the design of a more appropriate incentive scheme (see table).[4] As Weber stressed, these categories — which a widely used adaptation has labeled "traditional," "self-interest," "affective," and "shared purpose" — are ideal types, and real-life actions will frequently result from mixed motives. But we believe this typology provides a useful framework for health care organizations to apply in considering their incentive strategies.

Incentive mechanisms that are based on these four types of motives vary in their development as well as their ethical implications. For example, some provider organizations were formed explicitly to deliver most or all care for a well-defined patient population. Such organizations may invoke a culture emphasizing stewardship of resources to motivate clinicians to practice efficiently. The incentive for clinicians in this context consists in being part of the group and its tradition.

Financial incentives typically employ the instrumentally rational mode of self-interest, in which individuals and groups judge actions by their likely consequences. Examples include financial rewards for achieving quality- or efficiency-related targets. These incentives must be used with great care, since any such incentive, carried to an extreme, has potentially perverse consequences. Financial incentives in particular can introduce conflicts of interest that threaten a trusting patient–physician relationship; they also provide ready targets for external and internal critics who are unhappy with pressures for change.

Affective motives are frequently used in nonfinancial incentive schemes, such as performance rankings that are openly discussed in group settings, potentially leading to peer pressure. These techniques can be highly effective and can result in colleagues' learning from one another — for example, when data on variation in outcome or utilization of resources causes physi-

Weber's Motives of Social Action.					
Motive	**Corresponding Incentive**	**Mechanism**	**Example**	**Ethical Implications**	**Implications for Effectiveness**
Traditional	Be part of a community; increase social status	Habituation (e.g., an organization's cultivation of stewardship of public resources as part of clinical excellence)	Routine review among colleagues of appropriateness and outcomes of procedures	Emulation rather than critical reflection and conscious approval of customs or routines	In isolation, not likely to drive improvement from status quo in outcomes or efficiency
Self-interest	Reach individual, rationally defined ends (financial or nonfinancial)	Offering rewards conditional on reaching certain targets	Pay-for-performance program with financial incentive for achieving predefined quality or efficiency benchmarks	Potential for conflicts of interest, loss of trust, and compromised performance in areas that are not the focus of incentives	Limited scope — incentives usually focus on relatively few issues that are under the direct control of the individual or group
Affective	Receive positive emotional responses, feel appreciated	Individualized feedback on performance, peer pressure	Unblinded data on quality or efficiency presented in peer-group settings	Risk of manipulation through psychological or social techniques	Effective peer pressure requires social context in which clinicians are aware of having peers
Shared purpose	Realize goals that are considered intrinsically valuable	Joint commitment to achieve a valued and agreed-upon goal	Organizational commitment to address crisis (e.g., worse-than-expected mortality with cardiac surgery) or to sustained improvement of value (e.g., using performance report cards developed by clinical teams)	Potentially works with rather than against ethical standards, reinforcing physicians' sense of moral agency	Unlikely to be effective in driving improvement from status quo without use of other motives of social action

cians to reexamine their care. However, peer pressure is a powerful double-edged tool that carries some risk of manipulating behavior against individuals' moral judgments. It also requires that physicians consider themselves part of a community of colleagues whose opinions actually matter to them.

The shared-purpose orientation focuses attention on goals that are broadly accepted within a health care organization. To gain such acceptance, these goals must resonate with the personnel's sense of purpose. Thus, an organization's commitment to the triple aim of improved patient outcomes, better population health, and reduced costs cannot conflict with, and should indeed be shown to align with, the core principles of the medical profession, as expressed in the Physician Charter on Medical Professionalism (www.abimfoundation.org), including the primacy of patient welfare, patient autonomy, and social justice. Once a shared-purpose orientation is accepted by clinicians within an organization, it can be translated into a performance framework through incentive interventions, such as performance report cards for value-based care.[5]

Using incentives both effectively and ethically requires a shift away from a simple, one-lever model that relies on tradition, self-interest, or emotional responses to reward participants for a desired action (or punish them with financial loss or shame for an undesired one). Such an approach risks alienating physicians and other personnel. Rather, the challenge is to cultivate consensus on an organization's shared purpose and put that orientation into action through per-

formance measurement and use of the other types of incentives.

Badly designed incentive schemes that do not include the dimension of shared purpose can be perceived as manipulative, as disrespectful of physicians' professional identity, and as statements of power, with economics taking precedence over clinical concerns. An incentive scheme that is based on a robust sense of shared purpose, by contrast, protects and promotes physicians' sense of moral responsibility and ethical standards in a way that enables physicians to take ownership of it rather than feel it is imposed on them. Thus, instead of being passively graded or rewarded, physicians engage in the development, ongoing evaluation, and critical review of the incentive scheme, reporting any negative effects on the quality, efficiency, and equity of patient care.

We believe that shared-purpose orientations are not only a precondition for an ethical use of incentives but also essential for organizational effectiveness. When teams feel ownership of the shared goal, they can display creativity and flexibility that go beyond what's possible with incentives based on tradition, self-interest, or affective responses alone, while maintaining health professionals' sense of moral agency and responsibility. Practically speaking, however, a shared-purpose orientation alone is frequently not sufficient. Other types of incentives must be used to enhance organizations' effectiveness so that they may pursue the shared purpose.

It is not easy to design and implement such an array of incentives, with each element aimed thoughtfully at protecting or improving the institution's progress toward its aims. Again, examining Weber's motives of social actions can help us understand what would be suitable framework conditions: an institution whose tradition, culture, and mission health care professionals can identify with; a climate of respectful social interactions that allows physicians to uphold their professional standards and their sense of moral responsibility; transparency about institutional aims and the way they are promoted; a proactive attitude toward monitoring effects of incentives on the quality and fairness of patient care and incentive-related conflicts of interests perceived by physicians; and processes that encourage physicians and other stakeholders to engage in the development of a shared purpose and the continuous evaluation and revision of incentive schemes.

Under such conditions, incentives — in the sense of financial or nonfinancial drivers of action — need not be antithetical to a morally acceptable practice of medicine. In fact, they may prove to be valuable instruments in the attempt to realize both the economic and the ethical visions of high-performing health care delivery organizations.

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The Oregon ACO Experiment — Bold Design, Challenging Execution

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The Affordable Care Act (ACA) and the Center for Medicare and Medicaid Innovation emphasize accountable care organizations (ACOs) as mechanisms for achieving cost savings while ensuring high-quality care. ACOs are expected to contain costs through improvements in health care delivery and realignment of financial incentives, but their effectiveness remains unproved, and there are reasons for concern that they may fail.[1] Oregon has embarked on an ambitious